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ABSTRACT

The paper examines that phenomenon of widowhood, which has become a natural attribute of a woman's old age because of her greater life expectancy when compared with her husband. Researchers have discovered that, although problems of widowhood have attracted little serious inquiry, one of every five women who face conjugal bereavement need outside help to return to a state of physical and mental well-being. New patterns of health care for this ever-increasing number of women include "widow-to-widow programs" wherein trained widow aides give direct help to the recently bereaved, voluntary organizations sponsored by religious orders, and widow consultation services provided by private and government agencies. The author feels that further scientific inquiry is needed to identify those variables associated with high morale and those which correlate with low life satisfaction following bereavement. References are included. (Author/SES)

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DEVELOPMENTAL TASKS OF WIDOWHOOD FOR THE AGING WOMAN

Virginia Van Coevering

The average woman living in the United States today will spend the last seven years of her life alone. Only if she should marry a man six years her junior can she hope to even the odds in matching her life span to his. (Jacobson, 1966) Thus, widowhood has become a natural attribute of a woman's old age.

Men in our society prefer to marry women younger than themselves and since environmental insults kill off males faster than females at all ages, the age discrepancy accelerates over the years. The 1970 census figures show that the numbers of males over 65 increased from 5.8 million to 8.4 million in the last twenty years, or by 44.7 per cent. During this same period, the number of females over 65 went up from 6.5 to 11.6 million, a whopping 79.6 per cent. Older women are increasing twice as fast as older men. Already the woman surplus stands at 3,200,000. Most of this is comprised of widows. (Aging, June, 1971)

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This is a 20th century phenomenon. These three million elderly widows present a real and cogent social problem deserving of empirical study by inter-related gerentological disciplines. Yet the plight of the aged widow has attracted little serious inquiry. A search of the literature revealed only two doctoral dissertation studies.(Fulcomer 1942; Fitzelle 1952) Both researched the social adjustment of widows following bereavement. Other widowhood studies include death, dying and bereavement behavior, and demographic material on widows as part of larger studies of aging. (Kutner, 1956; Marris, 1958; Cumming and Henry, 1961; Shanas, Streib, 1965) Lowenthal, 1964; Berardo, 1966; Neugarten, 1968; Lopata, 1969; Parkes. 1970.)

The etiology of the aged-widow problem has evolved from the serendipitous combination of several factors: namely, advances in medical and scientific technology with government and societal supports. Childhood diseases have almost been wiped out. People are healthier and more of them are living out their genetically controlled life spans. But this extension of life has brought with it higher risk of morbidity and of a lowered quality of living. As a result providers of health care are becoming more involved in the alleviation of pain from alienation as more persons struggle with the crises of age-related losses. (Rogers,1970)

The major thrust of this paper will be to identify the developmental tasks of the older widow during the bereavement

period, to discuss the implications of these tasks for the psychologist, and to suggest a program which is showing promise as an instrument for better delivery of service to this high risk group.

Havighurst (1948) defined a developmental task as "a task that arises at or about a certain period in the life of the individual, the successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by society and difficulty with later tasks". Perhaps widowhood does not fit into this definition precisely, but there is ample evidence that all persons who lose a spouse go through the same stages of grieving and that unless they successfully perform the psychological tasks involved, morbidity and even mortality result.

Regardless of whether a woman loses her husband after a long, painful and exhausting illness, or whether she loses him without warning from an accident or heart attack, the first development task is the same: namely, to complete the grieving process successfully.

Although Berardo (1970) compiled a most extensive bibliography entitled Death, Bereavement and Widowhood, which includes 670 books and articles, Lindeman's 1944 classification of symptoms, compiled after the Boston Cocoanut Grove restaurant fire is still as good a criterion as there is for evaluating normal versus abnormal grieving behavior. (Lindeman, 1944) His symptomology of normal bereavement in its early stages includes:

1. Numbness and disbelief with a tendency to deny reality, a condition which may last from a few hours to several weeks.

2. Strong emotion, usually with an urge to cry;and various physical symptoms related to mental distress.

3. A state of panic as the survivor finds she is unable to get her mind off the subject of her loss. Overwhelming feelings of guilt and preoccupation with an image of the deceased.

4. Hostile reactions because the deceased has left her alone; unreasonable anger or jealousy toward those who are left alive; furious anger toward doctors or nurses blamed for the husband's death.

5. Loss of customary patterns of contact. Incapacitating feelings of sadness and loneliness.

Completing the grief work is particularly difficult for the American wife, Lindeman observed, "because only in America is the husband the most important companion, friend, confidant and emotional support that a woman has". This dependency is reinforced when the children leave home and again when the husband retires. The final blow comes when the husband dies.

Although the same physical symptoms are observed by the psycho-analyst, the emphasis for the grief work is placed on the release of the cathected object. Whether the object was loved or hated, a large part of the widow's reality is composed of potential responses which lack an appropriate object. (Cummings, 1969). There must be a psychological readjustment during which the mourner gives up the lost one by placing him

in symbolic perspective. Fixation, while the widow is trying to release the cathected object, may cause mental or physical disturbance.

One of the disturbances often observed is identification with the love object. (Freud, 1955.) Parker (1970) found that twenty per cent of his widow sample showed symptoms of identification with the dead husband. Examples included those widows who exhibited physical symptoms of the husband's last disease, a tendency to behave or think more like the spouse than when he was alive, and feeling as though the dead husband were actually located either inside their own bodies or in one of the children's.

Flynne (1970) reported a morbid case of long-term identification in a 65-year-old woman who had been living with a domineering abusive husband and an asthmatic and also domineering mother. When the husband died the widow showed no clear-cut grief reaction, but a year later when the mother died, the widow began to wear her mother's clothes, became slovenly, dirty, disheveled, and displayed classical asthma: wheezing, coughing, and expelling sputum. Her doctor could find no physical cause for the asthma, but the patient was unable to accept the physician's diagnosis and was not amenable to help. Fourteen months later, the patient suddenly recognized her own mirror image as that of her dead mother. Immediately, all sumptoms of asthma disappeared and the patient resumed wearing her own stylish clothes. The recognition had brought a spontaneous return to wellness.

Other researchers have observed a variety of morbid grief reactions. (Marris, 1958; Parkes, 1964); Lowenthal, 1964; Post, 1965). These are more apt to occur when the widow has nurtured her husband through a long emotion-draining final illness and has thus developed ambivalent feelings about his death, or when the mourner does not express emotion or refuses to deal with the memory and the pain of loss.

Morbid grief reactions may include any of the following symptoms:

Delay or postponement of grief reactions for weeks, months or years.

Over-activity without sense of loss.

Acquisition of the physical symptoms of the deceased's last illness.

Acquisition of other disease symptoms, for example: ulcerative colitis, rheumatoid arthritis, asthma.

Irritability and hostile reactions toward certain others which may continue indefinitely.

Such intense depression and anxiety with feelings of worthlessness that suicide or suicidal attempts may ensue.

In thinking of grief following bereavement, it is easier to understand the process by visualizing a model with three distinct parts. Tyhurst (1958) labeled the three stages: impact, recoil, and recovery. Transmission through these stages by the ego depends upon the personality of the survivor, the adequacy of her coping mechanism and the external supports

in the environment such as children, kin and peer groups. The psychosomatic symptoms listed above occur during the first two stages.

Concrete tasks of the initial period include:

1. Arranging for the funeral.

2. Determining the financial state of affairs.

3. Starting legal estate processing.

The recoil stage usually occurs when the funeral is over and the relatives have gone home. Tasks of this stage include:

1. Resuming household duties.

2. Adjusting to loneliness and the role of widow.

3. Making plans for the future.

The final phase, recovery, occurs from three months to as long as two years after death. Recovery tasks are:

1. Finding a new identiy.

2. Learning to live alone.

3. Learning to make decisions and accepting sole responsibility for them.

4. Finding a meaningful and emotional life.

5. Deciding on suitable living arrangements.

6. Developing a viable philosophy of life.

7. Accepting the physical aspects of the changed status and adjusting to them.

The last task, involving as it does,the reality of a shrinking life space, may prevent the widow from ever achieving high morale or life satisfaction. Often the most difficult problem of all is the impact of poverty. The median annual

income of Berardo's rural and urban widowhood population in Thurston County, Washington, was $712 in 1967. Census data indicate that widows have substantially lower incomes than the aged married, and that they represent the largest segment of the five million aged living below the poverty index. (U.S. Bureau of the Census, 1970). Poverty increases with chronological age and length of widowhood. Four of every ten aged women are over 75, therefore the number of widows in financial distress is multiplying.

Loneliness is the biggest problem of the black and mixed European ethnic widows in urban areas, according to the Lopata study. (Lopata, 1969). These widows tend to be socially isolated, particularly if they live in an apartment complex, have less than an eighth grade education, and were married to low-status husbands. The black widow lacks the necessary skills to become socially reintegrated.

Another factor which adds to the incidence of mental and physical breakdown is multiple adjustive crisis. Too many changes, coming too close together, often produce grave illness or pathological depression. (Holmes, 1971). In the course of his investigation, Holmes devised a scale in which he assigned point values to changes that often affect human beings. He found that loss of spouse caused the greatest stress (100 points) but if adjustments which often follow widowhood, such as change in residence, change in personal habits, income level, social activities and job follow in too quick succession, the risk of illness is dangerously increased.

and her family rarely seek professional help until they are jolted into action by a suicidal attempt, embarrassing bizarre behavior, or the widow's inability to function alone.

Evidence is now accumulating that there may be better solutions to the widowhood crisis. One of the most promising of these is the Widow to Widow program at the Harvard Laboratory of Community Psychiatry under the direction of Phyllis Silverman. This program grew out of the discovery that widows did not think of friends, family physicians or clergymen as being very helpful during the bereavement crisis. The preferred caretaker was another widow. The Harvard program matches the new widow with a widow in her neighborhood as to race and religion. The widow-aide contacts the new widow one month after the husband's death and helps in a variety of ways.

Widow-aide assistance may include a referral to other services in the community, a sympathetic shoulder to cry upon, or a sympathetic ear. Mostly, she alleviates anxiety about the future by demonstrating concretely that return to health is possible.

Silverman (1970) believes that the focus for working with widows and widowers should not be in the mental health clinic, but centered in those institutions that work with people as they go through the normal phases of the life cycle.

The Catholic archdiocese in many areas sponsors educational-social groups for widows, widowers and their children under the name Post Cana and Naim Conference. The THEO FOUNDATION (for They Help Each Other)begun by Mrs. Bea Decker under the auspices

of a Pittsburgh,Pa. Lutheran Church, is now operating nation-wide and offers a spiritually-oriented educational program for widows and their families, publishes a newsletter for all chapters, maintains a library and inspirational book service, provides guide lines and free literature to any group wishing to sponsor a local chapter, and draws participants from all sections of the country for its week-end retreats.

Perhaps we professionals have institutionalized the helping process so much that we are no longer able to serve certain people in need as well as the practitioner. If the patient does not wish to define herself as a problem, the psychologist will be unable to reach her.

One focus of the gerontologists' concern might be to help establish more widow to widow programs by offering their special expertise to help orient widow-aides and to be available when problems arise which the aides cannot handle.

Another source of direct help could be offered through a counselling service attached to a government or voluntary agency such as the multi-purpose senior center. Being watched with considerable interest is the Widows' Consultation Center in New York City which opened last September as a widow's information and advisory service under a grant from the Prudential Life Insurance Company. The first annual report of this demonstration project will be released shortly.

In the course of studying the tasks of adapting to widowhood in later life, I have come to the conclusion that the most important single adaptation the widow must make is to "find a new identity". I will be researching this subject at Wayne State

University during the coming year under Dr. Kastenbaum and hope to be able to add another chapter to the widowhood study when my dissertation is completed.

--FINIS--

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